reviews

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From Detached Concern to Empathy: Humanizing Medical Practice

Jodi Halpern

Oxford University Press, £29.50, pp 165
ISBN 0 19 511119 2

Rating: ★★★

Like all good inventions, Jodi Halpern's new and "controversial" model of empathy appears to be the result of common sense imaginatively applied. Empathy should, she asserts, result from a willingness on the part of the doctor to take cues from his own emotional responses to a patient's suffering. It requires more than the "detached concern" that she believes, a little harshly I think, is the norm. Nor is an insufficiently intellectual "sympathetic immersion" in a patient's woes enough. Through an awareness of the feelings that are induced within us we will succeed in communicating our interested concern, thereby encouraging the patient to reveal elements of her history that would otherwise remain hidden. Having become aware of her own emotional state, as reflected by the doctor, she will be stimulated to form new goals, dealing more rationally with the diagnosis or the disability that misfortune has delivered to her. Thus empathy becomes a therapeutic tool, easing the patient from what has frequently become a pessimistically "concretized" outlook on life. The patient rediscovers her autonomy.

One gets the sense that the author has worked backwards, seeking to "prove" what she knows and feels is right by invoking and examining the work of a long line of philosophers and medical writers. She studied philosophy before qualifying in psychiatry, and is well versed in the works of Descartes, Kant, Heidegger, Freud, and Stein, to name a few. As the foundations of the central thesis are put into place the reader finds himself wandering through an intensely philosophical and metaphysical building site.

The author hopes that her "road-map" to empathy will be used. If it appears impractical she risks the accusation of creating an impossible ideal within a book lined ivory tower. She asks that doctors allow their patients to "move them emotionally." "Curiosity" about the emotional states and the personal histories of those patients is a prerequisite.

Is this really feasible, for the younger, developing doctors at whom this book is aimed? It is difficult to square the delicacy of these interactions with the waves of resentment that trouble the house officer called to an ailing patient at the end of a 30 hour day, or the irritation felt by a registrar as she observes a litigiously inclined relative copy her every word into a notebook. This model of empathy depends on time, and on a limitless store of altruism; these obstructions to empathy are explored too swiftly.

I would recommend this book not as a manual, but as a vital reminder of how things *should* be, and as an insightful and philosophically educational analysis of how things probably are for the luckiest patients in our practices and hospitals.

Philip Berry *medical registrar, London*

Medicine and Literature: The Doctor's Companion to the Classics

John Salinsky

Radcliffe Medical Press, £17.95, pp 248
ISBN 1 85775 535 9

Rating: ★★

Attempts at defining the canon—let's be frank—appear fat and a bit dull. They are squat but worthy beasts—witness *The Western Canon* (New York: Harcourt Brace, 1994), Harold Bloom's list of a few years ago that made frail literate souls quake with guilt at how ill read they were. That's the trouble with classicists, they are better read than you will ever be.

Given a chance to read, we sometimes approach the classics with circumspection like Sherlock Holmes sniffing around a case. The more humble pulp favourites we assault like Dirty Harry. Most of us tend to search out a more dishevelled band of suspects as opposed to the canonically righteous.

"I think sometimes it hurts you when you stay too long at school"—so wrote John Cale and Lou Reed. Might that apply to some undergraduate medical courses where a five year Kulturkampf on non-scientific thinking wrecks any plan to inculcate reasonable communication skills, never mind empathy with the complexities of human behaviour? It sometimes seems that we are taught everything except what it is actually like to be a doctor. And that is where this guide argues that literature might help.

The works championed in this collection often reveal the limits of our knowledge, the ignorance we face daily dealing with disease. Kafka's disturbing and hallucinatory *A Country Doctor* might seem like just another day at the office for many contemporary physicians, but Bulgakov's horrendous experiences as a junior doctor remain powerfully vivid.

The recommendations in this guide are not controversial, the works well known. Like any other greatest hits compilation you can argue with those chosen. Sadly, the only time I found *A Midsummer Night's Dream* "hysterically funny" was back in 1973 when a smart teacher made the two Raskolnikov types in our class play Helena and Hermia.

The style in this guide is somewhat camp—witness the *Ulysses* section where the masterpiece is introduced as "another big one" with "naughty words" and where, "blow me," the chapter headings have been removed.

The author wishes he had time to tell us more about Dostoevsky's pedal fascination, but I think many will rejoice that we are spared the details. The aim of the book is laudable and will count as a success if it converts anyone to one of the great works. As for *The Brothers Karamazov*, one day I really must toe the line and read it.

John Quin *consultant physician, Royal Sussex County Hospital, Brighton*

Items reviewed are rated on a 4 star scale (4=excellent)

Psychiatrists get an offer they cannot refuse

The Sopranos, Channel 4,
Thursdays 10 30 pm (times may vary)

There is no doubt that the United States is way ahead of the United Kingdom in so many ways. This is especially evident when you attend scientific conferences there. While the former colonies were immersed in the third series, we back home were barely getting to grips with the first. Yes, *The Sopranos* is the talking point in transatlantic psychiatry. There would be enough to enjoy and discuss in this tale of postmodern Mafia hitmen and their families in present day New Jersey. But it is the extra dimension added by the inclusion of a psychiatrist as a central character, Dr Jennifer Melfi, which is the hook.

Tony Soprano, the local godfather, is an effective manager, capable of merciless brutality as well as touching sentiment. He deals with protection rackets, extortion, and, especially, liquidating rivals, while in parallel trying to deal with a sullen underachieving son, a wayward daughter, loopy sister, and demanding wife and mistress. In his sessions with Dr Melfi, Tony Soprano brings his frustrations and disappointments, his panic attacks and insomnia.

So, what are the talking points among psychiatrist viewers? First, we ask each other whether we would take on someone like Mr Soprano. "Only if he made us an offer we couldn't refuse" is the usual response. But most of our discussions centre on peer review of Dr Melfi and her clinical ability. She offers Tony eclectic psychotherapy, which is thoughtful, understated, and believable. The majority verdict is that she does a good job and is an excellent role model. Only the chic designer interior of the consulting room—a counterpoint to the Soprano family's opulent bad taste—edges towards fantasy. Here, Dr Melfi interprets dreams, which is what one would expect of any fictional psychiatrist. However, she also uses cognitive behaviour techniques, pointing out her client's negative cognitions, his tendency to catastrophise, as well as his behavioural avoidances. What will come as a surprise to many lay viewers is the sensible way in which she combines recommendations of psychotropic medication and appropriate discussion of their pros and cons with psychological techniques. This is the way the modern psychiatrist should approach therapy. It is a welcome touch of realism.

A recent episode (22 November) elevated this superior soap opera into deeply affecting drama. It featured the brutal rape of Jennifer Melfi by a stranger on her return to her car following a session with Soprano. This unleashed a raft of plot lines which have been unfolding in subsequent weeks: the bungled police arrest of the prime suspect; the strain on Melfi's relationship with her psychiatrist partner; and, of course, the effect of all this on the counter-transference.

Charmed by a psychopath: Dr Melfi

One of the ironies of Tony Soprano's therapy and a comment on the limits of psychoanalysis in general is its banality in relation to the extraordinary violence and degeneracy outside the room. Even understanding the roots of certain forbidden actions does not guarantee that they will be avoided. Dr Melfi acknowledges this in her sessions with Soprano. This also arises in her supervision with her own therapist, Dr Kupferberg. Again, the regular discussions she has with him about her difficulties with Tony Soprano provide an example of good practice. They allow her to reflect on what lies behind his macho, bluff exterior and why she reacts to it in the way that she does, in a supportive, non judgmental setting. "I've let myself be charmed by a psychopath," she muses.

Despite her insights, she really has no idea what her patient's life is really like. This begins to change as the ramifications of the rape spread. Melfi's cool self control starts to falter. She struggles to suppress her understandable desire for revenge on the attacker, drawn, significantly, from the same Italian American culture that she and her patient have grown out of. Into her impotent rage, expressed to Kupferberg, begin to seep the kind of compound four-syllable expletives that are the natural argot of Tony and his cronies and that Channel 4 euphemistically refers to as "strong language" in its pre-transmission health warning.

This intrusion is perhaps an ominous portent of future disorder, as is the fearsome black dog of Melfi's nightmare—a symbol of her fear of Tony's violence and her own yearning for retribution. The superego of Melfi's civilised values and the intellect begins to collide with the murky id that is Soprano's stock in trade. Such a convergence is not so incongruous. After all, the one thing Mafia hitmen have in common with psychiatrists is that both are, in a sense, part of the waste disposal business.

Tony David *professor of cognitive neuropsychiatry, Institute of Psychiatry, London*

WEBSITE OF THE WEEK

Taking a history Doctors always have a story to tell about how they made a brilliant diagnosis from the history alone. The patient is usually someone seen earlier by a rival doctor who failed to make the correct diagnosis, despite having all possible investigations to hand. It is usually an "I am so clever" story, but Matthew Bull (p 1339) has an honest and courageous story to tell. He recounts how he missed a diagnosis because he did not take the history properly.

History taking is an art one can never know enough about. So I set out to find a site that would teach me how to take a good medical history. One hour later I found nothing worth my while. www.medinfo.ufl.edu/year1/epc/docs/history.html was a long list and others alluded to history taking briefly or were about clinical examination (www.medinfo.ufl.edu/year1/bcs96/index.html, www.medinfo.ufl.edu/year1/bcs/index.html, www.clinicacayanga.f2s.com/History_PE.htm). The search terms "taking a history," "history taking," and "communication skills for doctors" all proved equally ineffective. When I tried "evidence based …" the list of sites dried up completely.

Information on history taking may be out there but it is not easy to find. For once the web is silent and the gurus of evidence based medicine virtually absent. It only helped to confirm a personal theory. History taking is an art, a performing art learned at the bedside watching a master artist in action, not from the web.

If readers know of any sites on taking a history that impressed you please do send a rapid response to bmj.com, and I will be grateful to you. If you find one on evidence based history taking I will provide evidence of my gratitude. But watch out, for it gets unusual out there in the information drought. You may come across http://mentalhealth.about.com/library/weekly/aa031201a.htm that talks about improving your communication with patients by learning to communicate with horses. It wouldn't surprise me if there was a site on how to milk a cow to improve your communication skills further (www.i'mwindingyouup.com). As for me, I'd rather learn from patients at the bedside. They teach you forever.

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PERSONAL VIEW

Great expectations: a relative dilemma

As a busy ward doctor I was finding it increasingly difficult to perform my clinical duties while also satisfying the multiple requests to speak to patients' relatives. At visiting time I walked faster than usual down the ward, eyes fixed firmly on the floor. Talking to relatives is an important part of the delivery of good patient care, but it takes time. Not only does it disrupt already tight working patterns, but also it often requires care, experience, and sensitivity. It is not easy to conduct an emotionally demanding interview, while respecting the patient's rights to confidentiality and addressing relatives' questions, fears, and anger.

Doctors spend an important amount of their time talking to patients' relatives. In an increasingly demanding NHS good communication has never been so crucial. The time spent talking to patients' relatives is time not spent attending to the other demands placed upon hospital staff. Improved communication should lead to improved service provision, but if there are numerous family members, each demanding details on separate occasions, at what point do these demands become unrealistic and possibly compromise patient care?

> The ward could not safely function if the doctor spent 90 minutes a day talking to relatives

It is difficult to find clear guidance on how much time doctors should spend talking to relatives. The Hippocratic Oath contains valuable guidance on confidentiality: "Whatever, in connection with my professional service, or not in connection with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret."

However, there is nothing in the Hippocratic Oath about responsibilities to patients' relatives. The General Medical Council's *Duties of a Doctor* states that the care of the patient should be the first concern. In October 2000 I wrote to the GMC asking for guidance on what doctors' responsibilities towards patients' relatives are. The GMC is currently considering my inquiry and will reply in more detail as soon as possible.

How much time do you spend talking to relatives? Is this time sufficient for you and/or the relatives? While working in an acute geriatric assessment ward I made a record of interviews with relatives and found that I spent 31 minutes a day talking to relatives. This did not include time preparing for interviews, time spent documenting each interview in the case notes, and time spent discussing the interview content with nursing staff. Balancing performing my clinical duties and finding this time was difficult and a source of much stress. To determine whether the relatives felt that they had enough time to speak to the ward doctor we sent questionnaires to a sample of relatives who documented that they would require 1.6 interviews a week. The interviews actually lasted 12.3 minutes and, calculated on a pro rata basis, this would total 87 minutes of interview time each day. The ward simply could not safely function if the ward doctor spent nearly 90 minutes talking to relatives each day.

Interestingly, 100% of relatives who answered our questionnaire thought that they were entitled to know "most" or "all" of the information regarding their relative; 75% thought that they were still entitled to this amount of information, even if their relative was opposed to any member of his or her family being informed.

Doctors hold private and sensitive information about patients. This must not be given to others unless the patient consents or when disclosure can be justified. Reasons for such disclosures include protection of patients or others from risk of death or serious harm, and the public interest, which ultimately only the courts can determine. There is evidence that, as a profession, we do not always practise what we preach with regard to patient confidentiality. A study conducted in the elevators of American hospitals reported that hospital staff were overheard to breach patient confidentiality during 7% of elevator rides that offered opportunity for conversation (*American Journal of Medicine* 1995;99:190-4). Not only should the medical profession be constantly reminding itself of the issues of patient confidentiality, but there is a strong argument to try to further educate the lay public so that misunderstandings of entitlement to information do not get in the way of good communication.

The results of my study were recently presented at a clinical meeting. It quickly became apparent that my own difficulties were common to most hospital doctors in the room. I also suspect that most relatives who read this article will have experienced difficulties trying to find a doctor with time to explain what is happening. The experience of the family faced with the terminal diagnosis of a loved one, who eventually managed to speak for five minutes to a tired doctor whose pager kept bleeping, is probably a common one. It is perhaps not surprising that such interviews can be deeply distressing for all concerned.

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I would like to thank E Spilg and J MacDonald, consultant physicians, medicine for the elderly, Gartnavel General Hospital, Glasgow, who helped with the study and this article

SOUNDINGS

I and *i*

There is, I think, something ethereal about *i*—the square root of minus one. I remember first hearing about it at school. It seemed an odd beast at that time—an intruder hovering on the edge of reality.

Usually familiarity dulls this sense of the bizarre, but in the case of *i* it was the reverse: over the years the sense of its surreal nature intensified. It seemed that it was impossible to write mathematics that described the real world in which it did not appear. And yet I always felt that it had, in some way, been slipped in with sleight of hand. It was something from beyond the looking glass.

Where did it come from? What exactly was it? Even its name—an imaginary number—heightened the sense of the unreal.

Problems that were formulated in the real world, as real equations, always had real solutions. *i* never came into the problem or into the solution. But to get from the problem *to* the solution in the world of *real* mathematics was either difficult or impossible.

And yet it seemed that if one moved into the plane of imaginary numbers then the problem and the solution were separated by only a couple of lines of working. In this strange, imaginary world the problem and the solution were almost adjacent. One could effortlessly slip up a dimension, take one step, and drop down with impossibly elegant and simple results.

It was like having a secret door into another world from which one could steal treasure and then return. But in this case the treasures were extraordinary and unexpected patterns.

For a while I thought that maybe *i* was just a device that made calculations in the real world easier. I nearly lost my faith. Did it really exist? If the earth and all of mankind were destroyed, would it still exist out there in a silent universe? However, there it was, answering my doubts, deeply embedded in worlds as disparate as quantum spin and special relativity.

I showed this piece to my registrar and he looked at me with that sad gaze he normally reserves for train spotters. How can one possibly get excited about something as dull as *i*?

I suppose the reason for me is that, in a universe that has embedded in its fabric something as impossibly strange as the square root of minus one, almost anything is possible.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*